symptoms in the patients studied and the normal controls is shown in considerable detail in 27 tables. The objective and subjective effect of thyroid administration is reported, and as expected, it was found to be most effective in the group of "Genuine Myxedema." The authors report that 11 of their cases which showed "hypometabolism" had been treated from 10 to 35 years previously for Graves' Disease.

This is a meticulous but, to this reviewer at least, it seems a sterile piece of clinical research. It is a laborious compilation of the symptoms in a group of patients who have in common a low metabolic rate. It contributes nothing new to our knowledge in that the only conclusion drawn is that a low metabolic rate does not always indicate hypothyroidism and therefore all such patients are not subjects for thyroid administration.

* * *

A GUIDE FOR THE TUBERCULOUS PATIENT. By G. S. Erwin, M.D., Medical Superintendent, Liverpool Sanatorium, Frodsham, Cheshire, and Henry C. Sweany, M.D., Medical Director of Research, Municipal Tuberculosis Sanatorium, Chicago. Grune & Stratton, New York. 1946. Price $1.50.

The need of the patient with tuberculosis for education in regard to the things he must do in order to get well and, not less important, to stay well, is universally recognized. Neither the doctor nor the nurse can take the time to do this verbally in all its phases. Early in the century a number of books written for the patient were published, that of Lawrason Brown having had the greatest popularity. It was brief and authoritative. A number of excellent texts have been written since. In some cases their success has been limited because of their bulk and because they too often went into detail about the possible complications. The result on the patient was somewhat similar to the legendary medical student who suffered in turn from most of the diseases as he studied them.

This little book combines in an unusual degree brevity and good sense. It also conforms to two essential requirements: it is written in a manner which will not arouse the patient's apprehensions about possible complications, and it presents an optimistic view without departing from scientific accuracy.

There are a few English colloquialisms which have not been corrected in the editing. For example, the term "screening" to denote fluoroscopy has long since fallen into disuse in this country, and has recently come to be used in an entirely different sense in connection with mass surveys.

As rest is still the basic factor in all our treatment, it is to be regretted that more space has not been devoted to a consideration of what is involved. The term is a simple one, but in practice its application becomes extremely complicated. It cannot be assumed that the patient will have constantly in mind the many modifications and degrees of rest before he leaves the sanatorium. Many patients cannot have the benefit of prolonged, or any, sanatorium training, and in any event instruction of their families is of great importance during the period of convalescence after their return home.

In the light of our present knowledge, one may question the dogmatic statement that "scientific research has shown that patients are in no way benefited in their ability to fight the infection by bringing the amount of vitamin C (in the blood) up to the level of normal health."

The dictum that the patient must always cough into his hand or handkerchief will be viewed with emphatic disfavor in this country, where patients are instructed to use only tissues (toilet tissues are quite satisfactory) for this purpose, and the use of the handkerchief or bare hand is considered highly dangerous.

Covering the dishes with boiling water for a few minutes would appear to be very inadequate for sterilization.

The wisdom of quoting the disappointing figures of only 60 per cent of discharged patients being alive five years after leaving the sanatorium, and 50 per cent of the patients never being fit for full competitive work in industry, is open to question, as is also their accuracy under present day treatment.

Despite these faults this is a very excellent handbook for the patient and his family, and is to be highly recommended. It is to be hoped that the publishers will shortly issue it in a more durable binding.

* * *

UTERINE CONTRACTILITY IN PREGNANCY. By Douglas P. Murphy, M.D., F.A.C.S., Assistant Professor of Obstetrics and Gynecology, and Research Associate in the Gynecean Hospital Institute of Gynecologic Research, University of Pennsylvania. J. B. Lippincott Company, Philadelphia. 1947. Price $5.00.

The author has presented the first complete scientific study of uterine contractions in pregnancy and labor under normal and experimental conditions. Many clinical observations have been confirmed. Based on 3,154 records of uterine contractions with the tocograph, the evidence has been divided into six sections, the last being an excellent discussion and summary.

The instrument used was first described by Lorand in 1933. It consists of a set of levers enclosed in a metal box only slightly larger than a deck of playing cards. The tocograph is held in place over the abdomen by an electric cord, with the patient lying on her back. The impulse is carried to a linear graphic record which records the oscillations on the kymograph. This method has the advantage of simplicity and the making of a permanent record. There is no danger of infection as with the intrauterine methods, and the possibility of a false stimulation as in the use of a balloon has also been eliminated. There is no discomfort to the patient. The instrument does not record maternal respiratory movements or pulsations of the aorta. Vaginal and rectal examination and catheterization, as well as lateral movement of the patient, does not affect the graph. Laughing, coughing, sneezing and movements of the body as a whole naturally cannot be eliminated.

The tocograph measures primarily the hardness of the uterus. As the uterus contracts the writing lever records a curve and in spite of thick abdominal walls, there is no appreciable error in the recording of the motility of the uterus or the fetus.

Fetal movements, as shown by this instrument, are of two types: those of the trunk and those of the extremities. The earliest that these movements have been demonstrated has been the 130th day of gestation. Of practical significance is the fact that failure to record movement of the fetus for 90 minutes, once it has been observed, is quite definite evidence of fetal death.

There are three periods of uterine activity in pregnancy as follows.

1. The quiescent period (the first 20 weeks of gestation).

2. The non-rhythmic period, from the 21st to the 38th week inclusive.

3. The rhythmic period, the 39th and 40th weeks.

During the first period activity is infrequent and weak. In the second period there is a great increase as to the time of occurrence, strength and duration, but the irregularity of contractions is most predominate feature. The third period is one of rhythmic activity. Contraction patterns of individual patients vary greatly, but they also are characteristic of the individual. While contractions become evident at the 21st week with the exception of the 37th and 38th weeks, they increase as the pregnancy advances. At the 32nd and 39th week there is a very marked increase in their strength.

Murphy's observation on posterior pituitary solution, estrogenic substance and morphine tend to bear out the clinical observations which have usually been recorded.

With the use of pituitary solution, the normal contractions are exaggerated and the amount of the drug which causes a clonic state and that which causes a tetonic contraction is very small. In the presence of increased tone the action is more forceful and also more apt to produce too strong and prolonged contractions. The dosage for stimulation of uterine contraction is 1 minim or less.

Extrogenic substances may produce increased motility, but the reaction is extremely variable. Morphine seems to diminish the frequency of contraction and gives the muscle a chance to rest which bears out the practical application of its use in prolonged labor.

Observations on inertia in labor, as well as disproportion, are facts which now are backed by a rather extensive observation of the behavior of the uterus in the last months of pregnancy and in labor.

This book has correlated a great amount of information in a very concise manner, and for the obstetrician who is interested in the relationship of uterine contractions to various conditions occurring in pregnancy and labor, a ready reference is now available. The use of various analgesias as they affect labor was not discussed, but undoubtedly this would be a valuable addition to the information obtained by the tocograph.

* * *

OFFICE ENDOCRINOLOGY. By Robert B. Greenblatt, B.A., M.D., C.M., Professor of Endocrinology, University of Georgia School of Medicine; Director, Endocrine Clinic, University Hospital, Augusta, Georgia. With a foreward by G. Lombard Kelly, M.D., Dean, University of Georgia School of Medicine. Third Edition. Charles C. Thomas, Publisher, Springfield, Illinois. Price $4.75.

The Third Edition of this growing book covers the entire field of office endocrinology with the exception of Diabetes Mellitus and does it clearly, simply and concisely in 46 short chapters and 280 pages. The print is large and can be read rapidly. Hormone physiology is simply and briefly but adequately described, thus presenting a rationale for endocrine treatment based on experimental physiology when one exists.

The vast field of empiricism in endocrinology is also thoroughly treated and so labeled. Treatment recommendations are definite as to dosage and schedule. This is an interesting and useful book which is certain to provide its readers with some new ideas in endocrinology. It covers the entire field, from acne to sterility. It is well illustrated. Diagnostic and treatment techniques are well described. It is to be commended particularly for its simplicity and brevity and yet completeness.